

<i>SERFF Tracking Number:</i>	<i>LWEL-126433352</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>AmFirst Insurance Company</i>	<i>State Tracking Number:</i>	<i>44452</i>
<i>Company Tracking Number:</i>	<i>AF-GVP (11/09)</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>Group Vision Care Policy</i>		
<i>Project Name/Number:</i>	<i>Group Vision Care Policy/AF-GVP (11/09)</i>		

Filing at a Glance

Company: AmFirst Insurance Company
 Product Name: Group Vision Care Policy
 TOI: H20G Group Health - Vision

SERFF Tr Num: LWEL-126433352 State: Arkansas
 SERFF Status: Closed-Approved-
 Closed

Sub-TOI: H20G.000 Health - Vision
 Filing Type: Form

Co Tr Num: AF-GVP (11/09) State Status: Approved-Closed
 Reviewer(s): Rosalind Minor
 Disposition Date: 01/05/2010
 Disposition Status: Approved-
 Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name: Group Vision Care Policy
 Project Number: AF-GVP (11/09)
 Requested Filing Mode:
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 01/05/2010

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Group Market Type: Employer
 Explanation for Other Group Market Type:
 State Status Changed: 01/05/2010
 Created By: Rebecca Ewing
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Rebecca Ewing
 Filing Description:

Re: Group Vision Care Plan - AmFirst Insurance Company

Dear Sir/Madam:

We have enclosed for your review and approval a filing of an Employer Group Vision plan. This is a group vision plan which will be marketed to employer groups in your state. These forms are new and do not replace any previously approved forms.

SERFF Tracking Number: LWEL-126433352 State: Arkansas
Filing Company: AmFirst Insurance Company State Tracking Number: 44452
Company Tracking Number: AF-GVP (11/09)
TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: Group Vision Care Policy
Project Name/Number: Group Vision Care Policy/AF-GVP (11/09)

The filing covers the following policy forms:

AF-GVP (11/09) Group Vision Care Policy
AF-GVC (11/09) Group Vision Care Certificate
AF-GRP VISION APP (11/09) Application for Group Vision Care Insurance

These forms will be marketed by licensed brokers and agents.

If you have any questions, please call me at (972) 850-3272 or email me at rewing@lewisellis.com.

Sincerely,
Rebecca Ewing

Company and Contact

Filing Contact Information

Rebecca Ewing, Compliance Consultant rewing@lewisellis.com
P. O. Box 851857 972-850-3272 [Phone]
2929 N. Central Expy., Ste. 200 972-850-3273 [FAX]
Dallas, TX 75085-1857

Filing Company Information

(This filing was made by a third party - lewisandellisincorporated)

AmFirst Insurance Company	CoCode: 60250	State of Domicile: Oklahoma
407 Briarwood Drive, Suite 201	Group Code: -99	Company Type:
Jackson, MS 39206	Group Name:	State ID Number:
(601) 956-2028 ext. [Phone]	FEIN Number: 640902785	

Filing Fees

Fee Required? Yes
Fee Amount: \$125.00
Retaliatory? Yes
Fee Explanation:
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AmFirst Insurance Company	\$125.00	12/30/2009	33194134

<i>SERFF Tracking Number:</i>	<i>LWEL-126433352</i>	<i>State:</i>	<i>Arkansas</i>
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/05/2010	01/05/2010

<i>SERFF Tracking Number:</i>	<i>LWEL-126433352</i>	<i>State:</i>	<i>Arkansas</i>
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Disposition

Disposition Date: 01/05/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Third Party Authorization Letter	Approved-Closed	Yes
Form	Group Vision Care Policy	Approved-Closed	Yes
Form	Group Vision Care Certificate	Approved-Closed	Yes
Form	Application for Group Vision Care Insurance	Approved-Closed	Yes

SERFF Tracking Number: LWEL-126433352 State: Arkansas

Filing Company: AmFirst Insurance Company State Tracking Number: 44452

Company Tracking Number: AF-GVP (11/09)

TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision

Product Name: Group Vision Care Policy

Project Name/Number: Group Vision Care Policy/AF-GVP (11/09)

Form Schedule

Lead Form Number: AF-GVP (11/09)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/05/2010	AF-GVP (11/09)	Policy/Cont ract/Fratern al Certificate	Group Vision Care	Initial		61.000	AF-GVP _1109_.pdf
Approved-Closed 01/05/2010	AF-GVC (11/09)	Certificate	Group Vision Care Certificate	Initial			AF-GVC _1109_.pdf
Approved-Closed 01/05/2010	AF-GRP VISION APP (11/09)	Application/ Enrollment Form	Application for Group Vision Care Insurance	Initial			AF-GRP VISION APP _1109_.pdf

AMFIRST INSURANCE COMPANY

ADMINISTRATIVE OFFICE:
5722 I-55 NORTH FRONTAGE ROAD
JACKSON, MISSISSIPPI 39211

GROUP VISION CARE POLICY

Group Name

Policy Number

State of Delivery [MISSISSIPPI]

Effective Date

Policy Term

Premium Due Date

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, AmFirst Insurance Company ("AMFIRST") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, including any Exhibits or state-specific Addenda, which are a part of this Policy.



David R. White, President

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I. **DEFINITIONS**

Key terms used in this Policy are defined:

- 1.01. **ADMINISTRATIVE SERVICES PROGRAM**: A group vision care plan whereby the Group pays AMFIRST for the Plan Benefits in addition to a monthly administrative fee.
- 1.02. **BENEFIT AUTHORIZATION**: Authorization from AMFIRST identifying the individual named a Covered Person of AMFIRST, and identifying those Plan Benefits to which the Covered Person is entitled.
- 1.03. **CONFIDENTIAL MATTER**: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons obtained while providing Plan Benefits hereunder.
- 1.04. **COPAYMENTS**: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
- 1.05. **COVERED PERSON**: An Enrollee or Eligible Dependent who meets AMFIRST's eligibility criteria and on whose behalf premiums have been paid AMFIRST, and who is covered under this Policy.
- 1.06. **ELIGIBLE DEPENDENT**: Any legal dependent of an Enrollee of a Group who meets the criteria for eligibility established by the Group and approved by AMFIRST in Article VI of this Policy under which such Enrollee is covered.
- 1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.
- 1.08. **ENROLLEE**: An employee or member of the Group who meets the criteria for eligibility specified under Article VI. ELIGIBILITY FOR COVERAGE.
- 1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by AMFIRST.

1.10. **GROUP**: An employer or other entity which contracts with AMFIRST for coverage under this Policy in order to provide Vision Care Coverage to its Enrollees and their Eligible Dependents.

1.11. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of AMFIRST.

1.12. **GROUP VISION CARE POLICY (also, "THE POLICY")**: The Policy issued by AMFIRST to a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of AMFIRST and receive Plan Benefits in accordance with the terms of such Policy.

1.13. **NETWORK PROVIDER**: An optometrist, ophthalmologist, optician or any entity licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with AMFIRST or AMFIRST's Network Provider to provide vision care services and/or vision care materials on behalf of Covered Persons of AMFIRST.

1.14. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with AMFIRST or AMFIRST's Network Provider to provide vision care services and/or vision care materials to Covered Persons of AMFIRST.

1.15. **PLAN BENEFITS**: The vision care services and vision care materials which Covered Person is entitled to receive by virtue of coverage under this Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.16. **RENEWAL DATE**: The date when the Policy shall renew, or terminate if proper notice is given.

1.17. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Policy, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under this Policy.

1.18. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to AMFIRST by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

II.

TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term:** This Policy is effective on the Effective Date and shall remain in effect for the Policy Term. At the end of the Policy Term, the Policy shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term that such party is unwilling to renew the Policy. If such notice is given, the Policy shall terminate at 11:59 p.m. on the last day of the Policy Term unless the parties agree on its renewal of the Policy. If the Policy continues on a month-to-month basis after the Policy Term, either party may terminate the Policy upon thirty (30) days advance notice to the other party.

If AMFIRST issues written renewal materials to the Group at least sixty (60) days before the end of the Policy Term and the Group fails to accept the new terms and/or rates in writing prior to the end of the Policy Term, this Policy shall terminate at 11:59 p.m. on the last day of the Policy Term.

2.02. **Early Termination Provision:** The Premium rate payable by the Group to AMFIRST under this Policy is based on an assumption that AMFIRST will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If the Group terminates this Policy before the end of the Policy Term or before the end of any subsequent renewal terms, for any reason other than material breach by AMFIRST, the Group shall be liable for the lesser of any deficit incurred by AMFIRST or the remaining payments which the Group would have paid for the full term of this Agreement. A deficit incurred by AMFIRST will be calculated by subtracting the cost of incurred and outstanding claims from the premiums received by AMFIRST from the Group. The Group agrees to pay AMFIRST within thirty-one (31) days of notification of the amount due.

III.

OBLIGATIONS OF AMFIRST

3.01. **Coverage of Covered Persons:** AMFIRST will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of who shall be referred to upon enrollment

as “Covered Persons.” To institute coverage, AMFIRST may require the Group to complete, sign and forward to AMFIRST a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

Following the enrollment of the Covered Persons, AMFIRST will provide the Group with Vision Care Brochures for distribution to Covered Persons. Such Brochures will summarize the terms and conditions set forth in this Policy.

3.02. **Provision of Plan Benefits**: Through its Network Provider (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) AMFIRST shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Network Provider. When a Covered Person seeks Plan Benefits from a Network Provider, the Covered Person must schedule an appointment and identify himself as a AMFIRST Covered Person so the Network Provider can obtain Benefit Authorization from AMFIRST. AMFIRST shall provide Benefit Authorization to the Network Provider to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. AMFIRST shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Group and the Covered Person’s past service utilization, if any. Any Benefit Authorization so issued by AMFIRST shall constitute a certification to the Network Provider that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

AMFIRST shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after AMFIRST has received a completed claim, unless special circumstances require additional time. In such cases, AMFIRST may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. **Provision of Information to Covered Persons:** Upon request, AMFIRST shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of this Policy shall be placed with the Group and also will be made available at the offices of AMFIRST for any Covered Persons. AMFIRST shall provide the Group with an updated list of Network Providers' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Network Provider directory through contacting AMFIRST's Customer Service Department's toll-free Customer Service telephone line, AMFIRST's Web site at www.AmFirstInsCoroup.com, or by written request.

3.04. **Preservation of Confidentiality:** AMFIRST shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Network Providers, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Policy, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on AMFIRST's Confidentiality policy may obtain a copy of the policy by contacting AMFIRST's Customer Service Department or AMFIRST's Web site at www.AmFirst.com.

3.05. **Emergency Vision Care:** When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Network Provider or Non-Member Provider. No prior approval from AMFIRST is required for a Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by AMFIRST only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If the Group has not purchased one of these plans, Covered Persons are not covered by AMFIRST for medical services and should contact a physician under the Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact AMFIRST's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.

IV.
OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees:** An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by AMFIRST and the Group. By the Effective Date of this Policy, the Group shall provide AMFIRST with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under this Policy as of that date. Thereafter, the Group shall supply to AMFIRST by the last day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from AMFIRST's coverage rosters for the next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon AMFIRST's request, the Group shall make available for inspection records regarding the coverage of Covered Persons under this Policy.

4.02. **Payment of Premiums:** By the 10th of each month, COMPANY shall remit to AMFIRST the premiums payable for the next month on behalf of Groups' Enrollees and Eligible Dependents to be covered under this Policy. The Schedule of Premiums incorporated in this Policy as Exhibit B provides the premium amount for each Covered Person. If payment for the Group is not received on time, AMFIRST may terminate all rights of such Group and the Group's Enrollees and Eligible Dependents. Such rights may be reinstated only in accordance with the requirements of this Policy.

AMFIRST may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving the Group at least sixty (60) days advance written notice. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by AMFIRST and the Group.

Notwithstanding the above, AMFIRST may increase premiums during a Policy Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums AMFIRST received from the Group.

4.03. **Grace Period:** The Group shall be allowed a Grace Period of thirty-one (31) days following the premium payment due date to pay premiums due under this Policy. During said Grace Period, this Policy shall remain in full force and effect for all Covered Persons of the Group. AMFIRST will consider late payments at the time of Policy renewal. Such payment may impact the Group's premium rates in future Policy Terms.

If COMPANY fails to make any premium payment due by the end of any Grace Period, AMFIRST may notify COMPANY that the premium payment has not been made, that coverage is canceled and that COMPANY is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the Grace Period through the effective date of termination. COMPANY shall also be responsible for any legal and/or collection fees incurred by AMFIRST to collect amounts due under this Policy. COMPANY will remit to AMFIRST premiums collected by Groups. In the event that payment for the total amount due is not collected from Groups within 30 days, COMPANY shall send lapse notice to the Group. In the event that payment is not remitted by the Group to COMPANY within 30 days of lapse notice, COMPANY shall retro term the Group. COMPANY shall send the terminated Groups' Enrollees and Dependents to AMFIRST through an electronic eligibility file within 10 business days of COMPANY terminating the Group in their system.

4.04. **Distribution of Required Documents:** The Group shall distribute to Enrollees any disclosure forms, plan summaries or other material required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by the Group no later than thirty (30) days after the receipt thereof, or as required under state law.

[4.05. **Risk-to-ASP Conversion Provision:** Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event the Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.]

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

5.01. **General:** By this Policy, the Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Policy may be amended or terminated by agreement between AMFIRST and the Group as indicated herein, without the consent or concurrence of Covered Persons. This Policy, and all Exhibits, Riders and attachments hereto, constitute AMFIRST's sole and entire undertaking to Covered Persons under this Policy.

As conditions of coverage, all Covered Persons under this Policy have the following obligations:

5.02. **Copayment for Services Received:** Where, as indicated in Exhibit A (Schedule of Benefits), Copayments are required for certain Plan Benefits, Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Network Provider the date services are rendered.

5.03. **Obtaining Services from Network Providers:** Benefit Authorization must be obtained prior to receiving Plan Benefits from a Network Provider. When a Covered Person seeks Plan Benefits, the Covered Person must select a Network Provider, schedule an appointment, and identify himself as a Covered Person so the Network Provider can obtain Benefit Authorization from AMFIRST. Should the Covered Person receive Plan Benefits from a Network Provider without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Network Provider will be considered a Non-Member Provider and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Submission of Non-Member Provider Claims:** If Non-Member Provider coverage is indicated in Exhibit A (Schedule of Benefits), written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-Member Providers shall be submitted by Covered Persons to AMFIRST within one hundred eighty (180) days of the date of service. AMFIRST may reject such claims filed more than one hundred eighty (180) days after the date of service.

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as

soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of one hundred eighty (180) days after the date of service.

5.05. **Complaints and Grievances:** Covered Persons shall report any complaints and/or grievances to AMFIRST at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to AMFIRST verbally or in writing. A Covered Person may submit written comments or supporting documentation concerning his complaint or grievance to assist in AMFIRST's review. AMFIRST will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after AMFIRST's receipt of the complaint or grievance. If AMFIRST determines that resolution cannot be achieved within thirty (30) days, AMFIRST will notify the Covered Person of the expected resolution date. Upon final resolution, AMFIRST will notify the Covered Person of the outcome in writing.

5.06. **Claim Denial Appeals:** If, under the terms of this Policy, a claim is denied in whole or in part, a request may be submitted to AMFIRST by Covered Person or Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include a Covered Person's authorized representative, where applicable.

a) **Initial Appeal:** The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the AMFIRST Enrollee's name, the AMFIRST Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by AMFIRST pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in AMFIRST's review. AMFIRST's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

a) **Denied Claims for Services Rendered:** within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) **Second Level Appeal:** If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of AMFIRST's response to the initial appeal, the Covered Person may submit a second appeal to AMFIRST along with any pertinent documentation. AMFIRST shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies:** When a Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or the Group should advise the Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

5.07. **Time of Action:** No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under this Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with AMFIRST. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices were submitted to AMFIRST, in accordance with the terms of this Policy.

5.08. **Insurance Fraud:** Any Group and/or person who intends to defraud, knowingly facilitates a fraud or submits an application or files a claim with a false or deceptive statement, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Policy for the Group or individual that committed the fraud.

VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria:** Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees:** To be eligible for coverage, a person must:

(1) currently be an employee or member of the Group, and

(2) meet the criteria established in the coverage criteria mutually agreed upon by the Group and AMFIRST.

(b) **Eligible Dependents:** If dependent coverage is provided, the persons eligible for dependent coverage are:

(1) the legal spouse of any Enrollee; and

(2) any unmarried child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; and

(3) as further defined by the Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to AMFIRST within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated or at such other times as AMFIRST may request proof, but not more frequently than annually.

6.02. **Documentation of Eligibility:** Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by the Group to AMFIRST in the manner provided hereunder, and

(b) for changes to an Eligible Dependent's status, the change has been reported by the Group to AMFIRST in the manner provided herein. As stated in Paragraph 4.01 above, AMFIRST may elect to audit the Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Policy.

6.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by AMFIRST. AMFIRST may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

All persons, entities, groups or associations who have contracted with MorganWhite, the administrator of this plan for AMFIRST, to receive Plan Benefits shall be considered eligible.

6.05. **Change in Family Status:** In the event the Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent, etc.] the Group shall provide notice of such change to AMFIRST via the next eligibility listing required under Paragraph 4.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or Enrollee's spouse acquires the right to control that child's health care. To continue coverage for a newborn or adopted child beyond the initial thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to AMFIRST.

VII.
CONTINUATION OF COVERAGE

7.01. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, AMFIRST shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VIII.
ARBITRATION OF DISPUTES

8.01. **Dispute Resolution**: Any dispute or question arising between AMFIRST and the Group or any Covered Person involving the application, interpretation, or performance under this Policy shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.02. **Procedure**: The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

8.03. **Choice of Law**: If any matter arises in connection with this Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of the Policy shall be the applicable law.

IX.
NOTICES

9.01. **Required Notices**: Any notices required to be given under this Policy to either the Group or AMFIRST shall be in writing and delivered by United States First Class Mail. Notices sent to the Group will be mailed to the address shown on the Group Application. Notices sent to AMFIRST shall be sent to the address shown in this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an

appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

X. **MISCELLANEOUS**

10.01. **Entire Policy**: This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of AMFIRST and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions. Communication materials prepared by Group for distribution to Enrollees do not constitute a part of this Policy.

10.02. **Indemnity**: AMFIRST agrees to indemnify, defend and hold harmless the Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of AMFIRST, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. The Group agrees to indemnify, defend and hold harmless AMFIRST, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of the Group, its officers or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability**: AMFIRST arranges for the provision of vision care services and materials through agreements with Network Providers. Network Providers are independent contractors and responsible for exercising independent judgement. AMFIRST does not itself directly furnish vision care services or supply materials. Under no circumstances shall AMFIRST or a Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

10.04. **Assignment**: Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto except as expressly authorized herein.

10.05. **Severability**: Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

10.06. **Governing Law**: This Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in compliance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulations, now or hereafter existing.

10.07. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.08. **Equal Opportunity**: AMFIRST is an Equal Opportunity employer.

10.09. **Communication Materials**: Communication materials created by the Group which relate to this Group Vision Care Policy must adhere to AMFIRST's Member Communication Guidelines distributed to the Group by AMFIRST. Such communication materials may be sent to AMFIRST for review and approval prior to use. AMFIRST's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that the Group's materials meet any applicable legal or regulatory requirements, including, but not limited to, ERISA requirements.

AMFIRST INSURANCE COMPANY
SCHEDULE OF BENEFITS
Plan Type

GENERAL

This Schedule of Benefits lists the Vision Care services and Vision Care materials to which Covered Persons of AMFIRST are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Network Providers or Non-Member Providers. This Schedule of Benefits forms a part of the Plan or Policy to which it is attached.

When Plan Benefits are received from Network Providers, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments. Plans may have different Plan Benefits from year one, year two, and year three. This is called an Increasing Benefits Plan.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Network Providers and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

A Copayment amount of [\$.00] shall be payable by the Covered Person to the Network Provider at the time services are rendered.

PLAN BENEFITS

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	[Covered in Full*]	[Up to \$ 46.00*]
Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.		

Subsequent regular eye examinations every -12- months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
<u>Lenses</u>		
Single Vision	Covered in full*	Up to \$ 45.00*
Bifocal	Covered in full*	Up to \$ 65.00*
Trifocal	Covered in full*	Up to \$ 85.00*
Lenticular	Covered in full*	Up to \$ 125.00*]

Available once every 12-- months.]

<u>Frames</u>	[Covered up to Plan Allowance*	Up to \$ 47.00*]
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[Available once every 12 months.]

*Less any applicable Copayment.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

Visually Necessary – Visually Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's AMFIRST or Non-AMFIRST Provider. Review and approval by AMFIRST are not required for a Covered Person to be eligible for Visually Necessary Contact Lenses. When Visually Necessary contact lenses are obtained from a Non-Member Provider, AMFIRST will provide an allowance toward the cost as outlined below.

NETWORK PROVIDER BENEFIT

Professional Fees and Materials
[Covered in full*]

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$ 210.00*]

Elective - Contact lenses for other than Visually Necessary circumstances

NETWORK PROVIDER BENEFIT

Professional Fees and Materials**
[Up to \$ 120.00 .00

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$ 105.00]

*Subject to Copayment

**Additional discount applies to Network Provider's usual and customary professional fees for contact lens evaluation and fitting (see section on Additional Discounts below).]

[ADDITIONAL DISCOUNT]

Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a Network Provider. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under this Policy.

Additionally, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off Network Provider professional fees for elective contact lens evaluations and fittings. Discounts are applied to the Network Provider's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the Network Provider who provided the covered eye examination. Contact lens materials are provided at the doctor's usual and customary charges. Additional discounts noted in this Schedule of Benefits are subject to change as deemed appropriate by AMFIRST with prior notification to the Group. NOTE: Discounts do not apply to Vision Care benefits obtained from Non-Member Providers.]

[LOW VISION BENEFIT]

The Low Vision Benefit is a Plan Benefit available to Covered Persons when specific benefit criteria are satisfied and when prescribed by Covered Person's AMFIRST or Non-AMFIRST Provider.

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Supplementary Testing	Covered in Full	Up to \$125.00
Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		

Supplemental Care Aids	75% of Cost	75% of Cost
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Subsequent low vision aids as Visually Necessary or Appropriate.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is \$1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision Benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Network Provider. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what AMFIRST would pay a Network Provider in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.]

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a $\pm.50$ diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Policy which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule of Benefits as covered Plan Benefits.

AMFIRST INSURANCE COMPANY

**ADMINISTRATIVE OFFICE:
5722 I-55 NORTH FRONTAGE ROAD
JACKSON, MISSISSIPPI 39211**

GROUP VISION CARE CERTIFICATE

This Group Vision Care Certificate (also called "Certificate") is provided to the Employee as evidence of insurance coverage under the Group Vision Care Policy issued to the Group, to the extent shown on the Schedule of Benefits. The insurance coverage is effective only with respect to the person(s) named on the application for whom insurance is requested, upon approval of such application by the Company and subject to the provisions of the Group Vision Care Policy. The principal provisions of the Group Vision Care Policy which have an effect on the insurance coverage are described in this Certificate. The Certificate Effective Date shown on the General Information page is subject to the Effective Date of an Employee's Insurance and the Effective Date of a Dependent's Insurance provisions of the Group Vision Care Policy. This Certificate is not a part of the Group Vision Care Policy; the benefits described in this Certificate are subject to all of the terms and conditions of the Group Vision Care Policy.

The Employee and the Group are as shown on the General Information page of this Certificate.

This Certificate replaces any certificate previously provided under the Group Vision Care Policy.



David R. White, President

General Information

Group Vision Care Benefit

[Provided through]
[Insured by]

[Name of Trust]

[Insured by]

AmFirst Insurance Company

Enrollee: [First Middle Last]
Dependent Insurance: [Included for Covered Dependents of the Enrollee; Not Included]
Certificate Number: [000000000000]
Certificate Effective Date: [Month Day, Year]
Employer: [Employer's Name]
Group: [Group's Name]
Group Policy Number: [0000000000]

(See Schedule of Benefits)

Claims and Correspondence should be directed to:

[Name of Administrator]
[Address]
[Phone Number]



David R. White, President

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I. **DEFINITIONS**

Key terms used in this Certificate are defined:

- 1.01. **ADMINISTRATIVE SERVICES PROGRAM**: A group vision care plan whereby the Group pays AMFIRST for the Plan Benefits in addition to a monthly administrative fee.
- 1.02. **BENEFIT AUTHORIZATION**: Authorization from AMFIRST identifying the individual named a Covered Person of AMFIRST, and identifying those Plan Benefits to which the Covered Person is entitled.
- 1.03. **CONFIDENTIAL MATTER**: All confidential information concerning the medical, personal, financial or business affairs of Covered Persons obtained while providing Plan Benefits hereunder.
- 1.04. **COPAYMENTS**: Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered.
- 1.05. **COVERED PERSON**: An Enrollee or Eligible Dependent who meets AMFIRST's eligibility criteria and on whose behalf premiums have been paid AMFIRST, and who is covered under the Policy.
- 1.06. **ELIGIBLE DEPENDENT**: Any legal dependent of an Enrollee of a Group who meets the criteria for eligibility established by the Group and approved by AMFIRST in Article VI of this Certificate under which such Enrollee is covered.
- 1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.
- 1.08. **ENROLLEE**: An employee or member of the Group who meets the criteria for eligibility specified under Article VI. **ELIGIBILITY FOR COVERAGE.**
- 1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by AMFIRST.

1.10. **GROUP**: An employer or other entity which contracts with AMFIRST for coverage under the Policy in order to provide Vision Care Coverage to its Enrollees and their Eligible Dependents.

1.11. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Covered Persons of AMFIRST.

1.12. **GROUP VISION CARE POLICY (also, "THE POLICY")**: The Policy issued by AMFIRST to a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Covered Persons of AMFIRST and receive Plan Benefits in accordance with the terms of such Policy.

1.13. **NETWORK PROVIDER**: An optometrist, ophthalmologist, optician or any entity licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with AMFIRST or AMFIRST's Network Provider to provide vision care services and/or vision care materials on behalf of Covered Persons of AMFIRST.

1.14. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with AMFIRST or AMFIRST's Network Provider to provide vision care services and/or vision care materials to Covered Persons of AMFIRST.

1.15. **PLAN BENEFITS**: The vision care services and vision care materials which Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.16. **RENEWAL DATE**: The date when the Policy shall renew, or terminate if proper notice is given.

1.17. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A to this Certificate, which lists the vision care services and vision care materials which a Covered Person is entitled to receive under the Policy.

1.18. **SCHEDULE OF PREMIUMS**: The document, attached hereto as Exhibit B, which states the payments to be made to AMFIRST by or on behalf of a Covered Person to entitle him/her to Plan Benefits.

AF-GVP (11/09)

II.

TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term:** The Policy is effective on the Effective Date and shall remain in effect for the Policy Term. At the end of the Policy Term, the Policy shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term that such party is unwilling to renew the Policy. If such notice is given, the Policy shall terminate at 11:59 p.m. on the last day of the Policy Term unless the parties agree on its renewal of the Policy. If the Policy continues on a month-to-month basis after the Policy Term, either party may terminate the Policy upon thirty (30) days advance notice to the other party.

If AMFIRST issues written renewal materials to the Group at least sixty (60) days before the end of the Policy Term and the Group fails to accept the new terms and/or rates in writing prior to the end of the Policy Term, the Policy shall terminate at 11:59 p.m. on the last day of the Policy Term.

2.02. **Termination of Coverage under this Certificate:** Coverage will terminate under this Certificate and any attached riders on the earliest date that any of the following events occur:

- a) For the Enrollee:
 - i.). On the date the Policy terminates;
 - ii.) As of the premium due date when the required premium remains unpaid, subject to the Grace Period;
 - iii.) On the premium due date following the date the Insured ceases to be an Eligible Person as defined in the Policy;
- 2. For the Eligible Dependents:
 - a. On the date the Enrollee's coverage terminates;
 - b. As of the premium due date when the required premium for the dependents and or spouse remains unpaid, subject to the Grace Period;
 - c. On the premium due date following the date the Insured Dependent ceases to be an Eligible Dependent.

If a mental or physical disability prevents an unmarried dependent child from self-support when he or she reaches the termination age, he or she may remain insured under the Policy. Proof of such incapacity and dependency must be furnished to Us within thirty-one (31) days of the child's attainment of the termination age and not more frequently than annually thereafter. Coverage will continue as long as Your coverage remains in force, premiums for the dependent child are paid, and the dependent child is incapable of self-support.

Termination of the insurance will be without prejudice to any claim incurred before the date of termination.

III.

OBLIGATIONS OF AMFIRST

3.01. **Coverage of Covered Persons:** AMFIRST will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of who shall be referred to upon enrollment as “Covered Persons.” To institute coverage, AMFIRST may require the Group to complete, sign and forward to AMFIRST a Group Application along with information regarding Enrollees and Eligible Dependents, and all applicable premiums. (Refer to VI. ELIGIBILITY FOR COVERAGE for further details.)

Following the enrollment of the Covered Persons, AMFIRST will provide the Group with Vision Care Brochures for distribution to Covered Persons. Such Brochures will summarize the terms and conditions set forth in the Policy.

3.02. **Provision of Plan Benefits:** Through its Network Provider (or through other licensed vision care providers where a Covered Person is eligible for, and chooses to receive Plan Benefits from a Non-Member Provider) AMFIRST shall provide Covered Persons such Plan Benefits listed in the Schedule of Benefits, Exhibit A hereto, subject to any limitations, exclusions, or Copayments therein stated. Benefit Authorization must be obtained prior to a Covered Person obtaining Plan Benefits from a Network Provider. When a Covered Person seeks Plan Benefits from a Network Provider, the Covered Person must schedule an appointment and identify himself as a AMFIRST Covered Person so the Network Provider can obtain Benefit Authorization from AMFIRST. AMFIRST shall provide Benefit Authorization to the Network Provider to authorize the provision of Plan Benefits to the Covered Person. Each Benefit Authorization will contain an expiration date, stating a specific time period for the Covered Person to obtain Plan Benefits. AMFIRST shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Group and the Covered Person’s past service utilization, if any. Any Benefit Authorization so issued by AMFIRST shall constitute a certification to the Network Provider that payment will be made, irrespective of a later loss of eligibility of the Covered Person, provided Plan Benefits are received prior to the Benefit Authorization expiration date.

AMFIRST shall pay or deny claims for Plan Benefits provided to Covered Persons, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after AMFIRST has received a completed claim, unless special circumstances require additional time. In such cases, AMFIRST may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.

3.03. **Provision of Information to Covered Persons:** Upon request, AMFIRST shall make available to Covered Persons necessary information describing Plan Benefits and how to use them. A copy of the Policy shall be placed with the Group and also will be made available at the offices of AMFIRST for any Covered Persons. AMFIRST shall provide the Group with an updated list of Network Providers' names, addresses, and telephone numbers for distribution to Covered Persons twice a year. Covered Persons may also obtain a copy of the Network Provider directory through contacting AMFIRST's Customer Service Department's toll-free Customer Service telephone line, AMFIRST's Web site at www.AmFirstInsCoroup.com, or by written request.

3.04. **Preservation of Confidentiality:** AMFIRST shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Network Providers, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under the Policy, including but not limited to sharing information with medical information bureaus, or complying with applicable law. Covered Persons and/or Groups that want more information on AMFIRST's Confidentiality policy may obtain a copy of the policy by contacting AMFIRST's Customer Service Department or AMFIRST's Web site at www.AmFirst.com.

3.05. **Emergency Vision Care:** When vision care is necessary for Emergency Conditions, Covered Persons may obtain Plan Benefits by contacting a Network Provider or Non-Member Provider. No prior approval from AMFIRST is required for a Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by AMFIRST only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If the Group has not purchased one of these plans, Covered Persons are not covered by AMFIRST for medical services and should contact a

physician under the Covered Persons' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact AMFIRST's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of the Policy.

IV. OBLIGATIONS OF THE GROUP

4.01. **Identification of Eligible Enrollees:** An Enrollee is eligible for coverage under the Policy if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by AMFIRST and the Group. By the Effective Date of the Policy, the Group shall provide AMFIRST with eligibility information, in a mutually agreed upon format and medium, to identify all Enrollees who are eligible for coverage under the Policy as of that date. Thereafter, the Group shall supply to AMFIRST by the last day of each month, eligibility information sufficient to identify all Enrollees to be added to or deleted from AMFIRST's coverage rosters for the next month. The eligibility information shall include designation of each Enrollee's family status if dependent coverage is provided. Upon AMFIRST's request, the Group shall make available for inspection records regarding the coverage of Covered Persons under the Policy.

4.02. **Payment of Premiums:** By the 10th of each month, COMPANY shall remit to AMFIRST the premiums payable for the next month on behalf of Groups' Enrollees and Eligible Dependents to be covered under the Policy. The Schedule of Premiums incorporated in this Certificate as Exhibit B provides the premium amount for each Covered Person. If payment for the Group is not received on time, AMFIRST may terminate all rights of such Group and the Group's Enrollees and Eligible Dependents. Such rights may be reinstated only in accordance with the requirements of this Policy.

AMFIRST may change the premiums set forth in Exhibit B (Schedule of Premiums) by giving the Group at least sixty (60) days advance written notice. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or there is a material change in Policy terms or conditions, provided any such change is mutually agreed upon in writing by AMFIRST and the Group.

Notwithstanding the above, AMFIRST may increase premiums during a Policy Term by the amount of any tax or assessment not now in effect but subsequently levied by any taxing authority, which is attributable to premiums AMFIRST received from the Group.

4.03. **Grace Period:** The Group shall be allowed a Grace Period of thirty-one (31) days following the premium payment due date to pay premiums due under the Policy. During said Grace Period, the Policy shall remain in full force and effect for all Covered Persons of the Group. AMFIRST will consider late payments at the time of Policy renewal. Such payment may impact the Group's premium rates in future Policy Terms.

If COMPANY fails to make any premium payment due by the end of any Grace Period, AMFIRST may notify COMPANY that the premium payment has not been made, that coverage is canceled and that COMPANY is responsible for payment for all Plan Benefits provided to Covered Persons after the last period for which premiums were paid in full, including the Grace Period through the effective date of termination. COMPANY shall also be responsible for any legal and/or collection fees incurred by AMFIRST to collect amounts due under the Policy. COMPANY will remit to AMFIRST premiums collected by Groups. In the event that payment for the total amount due is not collected from Groups within 30 days, COMPANY shall send lapse notice to the Group. In the event that payment is not remitted by the Group to COMPANY within 30 days of lapse notice, COMPANY shall retro term the Group. COMPANY shall send the terminated Groups' Enrollees and Dependents to AMFIRST through an electronic eligibility file within 10 business days of COMPANY terminating the Group in their system.

4.04. **Distribution of Required Documents:** The Group shall distribute to Enrollees any disclosure forms, plan summaries or other material required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by the Group no later than thirty (30) days after the receipt thereof, or as required under state law.

[4.05. **Risk-to-ASP Conversion Provision:** Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event the Group wishes to convert its method of funding from a risk

program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.]

V.
OBLIGATIONS OF COVERED PERSONS UNDER THE POLICY

5.01. **General:** By the Policy, the Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, the Policy may be amended or terminated by agreement between AMFIRST and the Group as indicated herein, without the consent or concurrence of Covered Persons. The Policy, and all Exhibits, Riders and attachments hereto, constitute AMFIRST's sole and entire undertaking to Covered Persons under the Policy.

As conditions of coverage, all Covered Persons under the Policy have the following obligations:

5.02. **Copayment for Services Received:** Where, as indicated in Exhibit A (Schedule of Benefits), Copayments are required for certain Plan Benefits, Copayments shall be the personal responsibility of the Covered Person receiving the care and must be paid to the Network Provider the date services are rendered.

5.03. **Obtaining Services from Network Providers:** Benefit Authorization must be obtained prior to receiving Plan Benefits from a Network Provider. When a Covered Person seeks Plan Benefits, the Covered Person must select a Network Provider, schedule an appointment, and identify himself as a Covered Person so the Network Provider can obtain Benefit Authorization from AMFIRST. Should the Covered Person receive Plan Benefits from a Network Provider without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Covered Person, the Network Provider will be considered a Non-Member Provider and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Submission of Non-Member Provider Claims:** If Non-Member Provider coverage is indicated in Exhibit A (Schedule of Benefits), written proof (receipt and the Covered Person's identification information) of all claims for services received from Non-Member Providers shall be submitted by Covered Persons to

AMFIRST within one hundred eighty (180) days of the date of service. AMFIRST may reject such claims filed more than one hundred eighty (180) days after the date of service.

Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of one hundred eighty (180) days after the date of service.

5.05. **Complaints and Grievances**: Covered Persons shall report any complaints and/or grievances to AMFIRST at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to AMFIRST verbally or in writing. A Covered Person may submit written comments or supporting documentation concerning his complaint or grievance to assist in AMFIRST's review. AMFIRST will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after AMFIRST's receipt of the complaint or grievance. If AMFIRST determines that resolution cannot be achieved within thirty (30) days, AMFIRST will notify the Covered Person of the expected resolution date. Upon final resolution, AMFIRST will notify the Covered Person of the outcome in writing.

5.06. **Claim Denial Appeals**: If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to AMFIRST by Covered Person or Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include a Covered Person's authorized representative, where applicable.

a) **Initial Appeal**: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the AMFIRST Enrollee's name, the AMFIRST Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim

number. The Covered Person may review, during normal working hours, any documents held by AMFIRST pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in AMFIRST's review. AMFIRST's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

a) **Denied Claims for Services Rendered:** within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) **Second Level Appeal:** If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of AMFIRST's response to the initial appeal, the Covered Person may submit a second appeal to AMFIRST along with any pertinent documentation. AMFIRST shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies:** When a Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation, or the Group should advise the Covered Person to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome.

5.07. **Time of Action:** No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with AMFIRST. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices were submitted to AMFIRST, in accordance with the terms of the Policy.

5.08. **Insurance Fraud**: Any Group and/or person who intends to defraud, knowingly facilitates a fraud or submits an application or files a claim with a false or deceptive statement, is guilty of insurance fraud. Such an act is grounds for immediate termination of the Policy for the Group or individual that committed the fraud.

VI.
ELIGIBILITY FOR COVERAGE

6.01. **Eligibility Criteria:** Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) **Enrollees:** To be eligible for coverage, a person must:

(1) currently be an employee or member of the Group, and

(2) meet the criteria established in the coverage criteria mutually agreed upon by the Group and AMFIRST.

(b) **Eligible Dependents:** If dependent coverage is provided, the persons eligible for dependent coverage are:

(1) the legal spouse of any Enrollee; and

(2) any unmarried child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible; and

(3) as further defined by the Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he remains chiefly dependent on the Enrollee for support and the Enrollee's coverage remains in force; PROVIDED that satisfactory proof of the dependent's incapacity can be furnished to AMFIRST within thirty-one (31) days of the date the Eligible Dependent's coverage would have otherwise terminated or at such other times as AMFIRST may request proof, but not more frequently than annually.

6.02. **Documentation of Eligibility:** Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by the Group to AMFIRST in the manner provided hereunder, and

(b) for changes to an Eligible Dependent's status, the change has been reported by the Group to AMFIRST in the manner provided herein. As stated in Paragraph 4.01 above, AMFIRST may elect to audit the Group's records in order to verify eligibility of Enrollees and dependents and any errors. Subject to the terms of Paragraph 4.03 above, only persons on whose behalf premiums have been paid for the current period shall be entitled to Plan Benefits hereunder. If a clerical error is made, it will not affect the coverage a Covered Person is entitled under the Policy.

6.03. **Retroactive Eligibility Changes:** Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by AMFIRST. AMFIRST may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination.

All persons, entities, groups or associations who have contracted with MorganWhite, the administrator of this plan for AMFIRST, to receive Plan Benefits shall be considered eligible.

6.05. **Change in Family Status:** In the event the Group is notified of any change in a Covered Person's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of Dependent, etc.] the Group shall provide notice of such change to AMFIRST via the next eligibility listing required under Paragraph 4.01. If notice is given, the change in the Covered Person's status will be effective on the first day of the month following the change request, or at such later date as may be requested by or on behalf of the Covered Person. Notwithstanding any other provision in this section, a newborn child will be covered during the thirty-one (31) day period after birth, and an adopted child will be covered for the thirty-one (31) day period after the date the Enrollee or Enrollee's spouse acquires the right to control that child's health care. To continue coverage for a newborn or adopted child beyond the initial thirty-one (31) day period, the Group must be properly notified of the Enrollee's change in family status and applicable premiums must be paid to AMFIRST.

VII.
CONTINUATION OF COVERAGE

7.01. **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies, AMFIRST shall make the statutorily-required continuation coverage available for purchase in accordance with COBRA.

VIII.
ARBITRATION OF DISPUTES

8.01. **Dispute Resolution**: Any dispute or question arising between AMFIRST and the Group or any Covered Person involving the application, interpretation, or performance under the Policy shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.02. **Procedure**: The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

8.03. **Choice of Law**: If any matter arises in connection with the Policy which becomes the subject of arbitration or legal process, the law of the State of Delivery of the Policy shall be the applicable law.

IX.
NOTICES

9.01. **Required Notices**: Any notices required to be given under the Policy to either the Group or AMFIRST shall be in writing and delivered by United States First Class Mail. Notices sent to the Group will be mailed to the address shown on the Group Application. Notices sent to AMFIRST shall be sent to the address shown in the Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an

appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.

X. **MISCELLANEOUS**

10.01. **Entire Policy:** The Policy, the Group Application, the Evidence of Coverage, and all Exhibits, Riders and attachments hereto, and any amendments hereto, constitute the entire agreement of the parties and supersedes any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of AMFIRST and attached hereto to be valid. No agent has the authority to change the Policy or waive any of its provisions. Communication materials prepared by the Group for distribution to Enrollees do not constitute a part of the Policy.

10.02. **Indemnity:** AMFIRST agrees to indemnify, defend and hold harmless the Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of AMFIRST, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. The Group agrees to indemnify, defend and hold harmless AMFIRST, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of the Group, its officers or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability:** AMFIRST arranges for the provision of vision care services and materials through agreements with Network Providers. Network Providers are independent contractors and responsible for exercising independent judgement. AMFIRST does not itself directly furnish vision care services or supply materials. Under no circumstances shall AMFIRST or a Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with the Policy.

10.04. **Assignment**: Neither the Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred without the prior written consent of both parties hereto except as expressly authorized herein.

10.05. **Severability**: Should any provision of the Policy be declared invalid, the remaining provisions shall remain in full force and effect.

10.06. **Governing Law**: The Policy shall be governed by and construed in accordance with applicable federal and state law. Any provision that is in conflict with, or not in compliance with, applicable federal or state statutes or regulations is hereby amended to conform with the requirements of such statutes or regulations, now or hereafter existing.

10.07. **Gender**: All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.08. **Equal Opportunity**: AMFIRST is an Equal Opportunity employer.

10.09. **Communication Materials**: Communication materials created by the Group which relate to the Group Vision Care Policy must adhere to AMFIRST's Member Communication Guidelines distributed to the Group by AMFIRST. Such communication materials may be sent to AMFIRST for review and approval prior to use. AMFIRST's review of such materials shall be limited to approving the accuracy of Plan Benefits and shall not encompass or constitute certification that the Group's materials meet any applicable legal or regulatory requirements, including, but not limited to, ERISA requirements.

AMFIRST INSURANCE COMPANY
SCHEDULE OF BENEFITS
Plan Type

GENERAL

This Schedule of Benefits lists the Vision Care services and Vision Care materials to which Covered Persons of AMFIRST are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services, as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Network Providers or Non-Member Providers. This Schedule of Benefits forms a part of the Plan or Policy to which it is attached.

When Plan Benefits are received from Network Providers, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are available and received from Non-Member Providers, the Covered Person is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments. Plans may have different Plan Benefits from year one, year two, and year three. This is called an Increasing Benefits Plan.

COPAYMENT

The benefits described herein are available to each Covered Person subject only to payment of the applicable Copayment by the Covered Person. Copayments are required for Plan Benefits received from Network Providers and Non-Member Providers. Covered Persons must also follow the proper procedures for obtaining Benefit Authorization.

A Copayment amount of [\$.00] shall be payable by the Covered Person to the Network Provider at the time services are rendered.

PLAN BENEFITS

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
VISION CARE SERVICES		
<u>Eye Examination</u>	[Covered in Full*]	[Up to \$ 46.00*]
Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.		

Subsequent regular eye examinations every -12- months.

*Less any applicable Copayment.

VISION CARE MATERIALS

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
<u>Lenses</u>		
Single Vision	Covered in full*	Up to \$ 45.00*
Bifocal	Covered in full*	Up to \$ 65.00*
Trifocal	Covered in full*	Up to \$ 85.00*
Lenticular	Covered in full*	Up to \$ 125.00*]

Available once every 12-- months.]

<u>Frames</u>	[Covered up to Plan Allowance*	Up to \$ 47.00*]
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[Available once every 12 months.]

*Less any applicable Copayment.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.

CONTACT LENSES

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses again for 12 months and frames for 12 months.

Visually Necessary – Visually Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's AMFIRST or Non-AMFIRST Provider. Review and approval by AMFIRST are not required for a Covered Person to be eligible for Visually Necessary Contact Lenses. When Visually Necessary contact lenses are obtained from a Non-Member Provider, AMFIRST will provide an allowance toward the cost as outlined below.

NETWORK PROVIDER BENEFIT

Professional Fees and Materials
[Covered in full*]

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$ 210.00*]

Elective - Contact lenses for other than Visually Necessary circumstances

NETWORK PROVIDER BENEFIT

Professional Fees and Materials**
[Up to \$ 120.00 .00

NON-MEMBER PROVIDER BENEFIT

Professional Fees and Materials
Up to \$ 105.00]

*Subject to Copayment

**Additional discount applies to Network Provider's usual and customary professional fees for contact lens evaluation and fitting (see section on Additional Discounts below).]

[ADDITIONAL DISCOUNT]

Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a Network Provider. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under the Policy.

Additionally, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off Network Provider professional fees for elective contact lens evaluations and fittings. Discounts are applied to the Network Provider's usual and customary fees for such services and are available within twelve (12) months of the covered eye examination from the Network Provider who provided the covered eye examination. Contact lens materials are provided at the doctor's usual and customary charges. Additional discounts noted in this Schedule of Benefits are subject to change as deemed appropriate by AMFIRST with prior notification to the Group. NOTE: Discounts do not apply to Vision Care benefits obtained from Non-Member Providers.]

[LOW VISION BENEFIT]

The Low Vision Benefit is a Plan Benefit available to Covered Persons when specific benefit criteria are satisfied and when prescribed by Covered Person's AMFIRST or Non-AMFIRST Provider.

	<u>NETWORK PROVIDER BENEFIT</u>	<u>NON-MEMBER PROVIDER BENEFIT</u>
Supplementary Testing	Covered in Full	Up to \$125.00
Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.		
Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids as Visually Necessary or Appropriate.

Copayment for Supplemental Aids: 25% payable by Covered Person.

Benefit Maximum

The maximum benefit available is \$1000.00 (excluding Copayment) every two years.

NON-MEMBER PROVIDER BENEFIT

Low Vision Benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Network Provider. The Covered Person should pay the Non-Member Provider his full fee. The Covered Person will be reimbursed in accordance with an amount not to exceed what AMFIRST would pay a Network Provider in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.]

EXCLUSIONS AND LIMITATIONS OF BENEFITS

PATIENT OPTIONS

The Policy is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Policy will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a $\pm.50$ diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under the Policy which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule of Benefits as covered Plan Benefits.

AmFirst Insurance Company

P.O. Box 14067
Jackson, MS 39236-4067

APPLICATION FOR GROUP VISION CARE INSURANCE

Application is hereby made to **AmFirst Insurance Company** for Group Vision Care Benefits.

1. **Name of Employer or Applicant:** _____
2. **Address:** _____

3. **Telephone Number:** _____
4. **Number of Eligible Employees:** _____
5. **Nature of Business:** _____
6. **Requested Effective Date:** _____
7. **Contributions by Employer:**
Employee Coverage _____ %
Dependent Coverage _____ %
8. **Premiums are payable monthly** except as requested otherwise by the Employer and agreed to in writing by the Company.
9. **Full-time employees** are those who work a minimum of _____ hours per week.

For outline of benefits, please review attached flyer.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For the Employer or Applicant

For Amfirst Insurance Company

Title

Title

Date

Date

<i>SERFF Tracking Number:</i>	<i>LWEL-126433352</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>AmFirst Insurance Company</i>	<i>State Tracking Number:</i>	<i>44452</i>
<i>Company Tracking Number:</i>	<i>AF-GVP (11/09)</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>Group Vision Care Policy</i>		
<i>Project Name/Number:</i>	<i>Group Vision Care Policy/AF-GVP (11/09)</i>		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/05/2010
Comments:			
Attachments:			
	Readability Certification.pdf		
	Arkansas-Rule&Regulation19.pdf		
	AR-Notice.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/05/2010
Comments:			
	See Form Schedule.		
		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization Letter	Approved-Closed	01/05/2010
Comments:			
Attachment:			
	Lewis&Ellis Authorization letter 8-6-09.pdf		

December 22, 2009

State of Arkansas

Re: Readability Certification for Policy Forms
AmFirst Insurance Company

To Whom It May Concern:

The following forms have been tested for readability and meet the minimum reading ease score as required by your state.

Form Number	Flesch Score
AF-GVP (11/09), et al	61



David White, President
AmFirst Insurance Company

Arkansas – Rule and Regulation 19 Certification of Compliance

Please accept our assurances that this submission meets the provisions of Regulation 19 along with all other applicable requirements of the Arkansas Insurance Department.

AmFirst Insurance Company

A handwritten signature in black ink, appearing to read "David L. White". The signature is fluid and cursive, with the first name "David" and last name "White" clearly distinguishable.

David White, President

Date: 11/22/09

**IMPORTANT INFORMATION FOR
ARKANSAS POLICYOWNERS**

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

AmFirst Insurance Company
P.O. Box 14067
Jackson, Mississippi 39236

Telephone: 1-800-252-3439

Agent _____
Address _____

Telephone _____

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494
1-501-371-2640

E-Mail: Insurance@mail.state.ar.us
Web Site: www.state.ar.us/insurance

AF-NOTICE-AR



AmFirst
Insurance Company

August 6, 2009

Lewis & Ellis, Inc.
2929 North central Expressway, Suite 200
P.O. Box 85187
Richardson, Texas 75085

To Whom It May Concern:

This letter or a copy thereof, confirms the authority of Lewis & Ellis, Inc. to submit on behalf of AmFirst Insurance Company (the Company), the required forms and rates for any insurance products to the insurance departments of those jurisdictions in which the Company is licensed, and to represent the Company in the negotiation of the approval of said forms and rates, including the provision of necessary assurances and commitments regarding specific conditions of the forms to secure said approvals.

This authorization shall be valid until such time as it is revoked by the Company.

Sincerely,

Richard L. Eaton
Chief Financial Officer
AmFirst Insurance Company